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Origins of the "Third Psychiatric Revolution": The Community Mental Health Centers Act of 1963

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Abstract. In recent decades the community mental health movement has achieved a dramatic reduction in the census of state and county mental hospitals in the United States, and hundreds of federally-funded community mental health centers have been established nationwide. At the same time, national controversy has arisen in response to what in places has seemed the haphazard process of implementing "deinstitutionalization" and the fate of many chronically mentally ill persons who are without needed social services and psychological care. Despite the widespread attention that this contemporary program has received, theoretical analysis of the complex social, scientific, intellectual, and political origins of America's community mental health policy remains deficient. This article examines the background and development of the Community Mental Health Centers Act of 1963, tracing how an important shift in national policy toward the mentally ill grew out of changing perceptions—among policymakers, professional groups, and the general citizenry in the post–World War II era—of the nature of the problem of mental illness.

Historians and political scientists have typically described the Kennedy administration as a period of unfulfilled promise in national policymaking.[1] Particularly in the area of social welfare, it is claimed, the vigorous rhetoric of a "New Frontier" fell flat before a deadlocked Congress and a quiescent public that failed to supply the backing for social change. According to this analysis, only the combined effect of a presidential assassination, the landslide Democratic victory of 1964, and Lyndon Johnson's unique legislative abilities managed to propel America into a new burst of domestic reform during the mid-1960s.

In drawing this picture, analysts have curiously overlooked the Community Mental Health Centers Act of 1963 (CMHC Act).[2] Signed into law less than one month before President Kennedy's death, this watershed development in policy officially signaled the start of an era of community mental health and "deinstitutionalization" practices that continue to define the public mental health system

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into the early 1980s. Writing in 1964, Robert Felix, then director of the National Institute of Mental Health, proclaimed: "This statute has touched off one of the most dynamic revolutions in the history of the mental health movement."[3] While not always approving of the way community mental health programs have been implemented, most scholars have since concurred, some going so far as to term community mental health "the third great revolution in psychiatry of this century," after the emergence of psychoanalysis in the 1910s and '20s and the introduction of psychotropic drugs in the 1950s.[4]

What accounts for the adoption of this "bold new approach" in policy, during a period not otherwise notable for major social welfare policy innovations?[5] Existing theoretical work, which is limited, advances two principal explanations that directly oppose each other.[6] What might be called a "progressive" view maintains that community mental health legislation originated with a small group of federal officials, congressmen, and activist reformers, who used the national policymaking apparatus as a vehicle for rational and benevolent reform of existing mental health practices in America.[7] The second, or radical, explanation is that, far from a humanitarian advance, the CMHC Act represented a new style of community-based social control, one that is better suited than institutionalization to America's current stage of "welfare capitalism."[8]

An alternative point of view is possible. Rather than view the CMHC Act as the product of an elite—either benevolent or controlling—we can seek its sources in a new image of the mentally ill that became prevalent in American society during the decades following World War II. According to this perspective, the policymaking process stands at the tip of a deep and mostly submerged iceberg of social, intellectual, professional, and public-opinion influences. Adopting this viewpoint, the present analysis begins far below the waterline, and works its way slowly to the surface, where political acts make larger cultural currents clearly visible.

Social and intellectual background

A number of major social, scientific, and intellectual developments stimulated a reshaping of the mental health system in the post–World War II era. Each in its own way helped to alter existing perceptions of the problem of mental illness; and the new perceptions, in turn, contributed to a sweeping change in national policy.

World War II. The Second World War itself had a powerful influence in several areas at once. In the first place, the war provided frightening evidence of the extent of mental illness in American society.[9] From 1942 to 1945, approximately 12 percent of all men screened for induction into the armed services were rejected on neurological or psychiatric grounds, a number accounting for nearly 40 percent of all rejections. And many men judged fit to enter service eventually were discharged due to neuropsychiatric problems —about 37 percent of all personnel

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leaving the Army because of disability, for example. In less abstract terms, this loss of well over 2,000,000 men because of neuropsychiatric disorders exceeded the total number of servicemen who were stationed in the Pacific during World War II. Not only did such a revelation cause many in public and private life to recognize that psychiatric problems had weakened the American war effort, it also raised the uncomfortable issue of how many more civilians might be similarly disabled. This was indeed an ominous question, since the pool of young men considered for military service was thought to represent the finest that America had to offer.

The problem of psychiatric casualties among servicemen induced the military to experiment with new methods of psychiatric treatment, a process that led to some major therapeutic advances.[10] This was another sense in which wartime experiences gave form to the post-war mental health system. For example, military psychiatrists demonstrated that early intensive treatment could result in high rates of recovery for even diagnosed psychotics, "a group who in civilian settings so frequently became only custodial cases."[11] They also made greater use of sedation and hypnosis as therapeutic agents. Perhaps most important, military psychiatrists witnessed directly certain social and environmental aspects of psychiatric disorder, and attempted to incorporate this insight into treatments such as group therapy.

It is possible to identify still a third major effect of war-related experiences on mental health care in America. The existence of large numbers of psychiatrically disabled servicemen and veterans undoubtedly served to lessen the longstanding stigma associated with emotional breakdown. Here were men injured in service to their country, and their country owed them an honorable response. A brief vignette reported by mental health historian Jeanne Brand helps to make the point. Immediately after the war, high-level personnel in the Division of Mental Hygiene of the Public Health Service prepared legislation for America's first national mental health program, which Congress subsequently passed as the National Mental Health Act of 1946. During the Senate hearings on this bill, a Marine captain described his recent psychiatric hospitalization and the dire need to expand the kinds of therapeutic efforts that had enabled his own recovery. Brand explains: "Offering the testimony on his own initiative, the young flyer's words carried no self-pity, but an unquestionable sincerity of interest in the need for active treatment programs for the mentally ill. His statement moved his audience deeply."[12]

In these ways, the Second World War went far toward alerting Americans to the scope of the problem of mental illness and the value of new treatments. It also revealed that mental illness could afflict anyone—not only the poor, ethnic minorities, or other social outcasts —and that situational factors could contribute to emotional breakdown. The outcome was a subtle shift in both the image of mental illness and the kinds of policy actions deemed suitable for public discussion:[13]

> Prior to this time [passage of the National Mental Health Act], mental illness was considered to be a medical problem and left to state governments and the medical profession. World War II brought to light the growing number of individuals with emotional disorders. Mental illness became a focus and responsibility of the Federal government because it was now decreed to be in the *social domain.*

Studies and exposés. A second major influence on the mental health system in the post-war years was the quickly spreading critique of mental hospitals. Advanced with equal fervor by popular and scholarly writers alike, this critique began as a movement to discredit contemporary patterns of institutional care, and ended by contributing in its own way to a new understanding of the problem of mental illness.

The movement actually originated during the war with the activities of conscientious objectors (COs).[14] Responding to serious manpower shortages, the Selective Service began in 1942 to assign large numbers of conscientious objectors to work as attendants in mental hospitals; by 1945, about 2,000 COs had done duty in nearly 60 institutions. Upon arriving at their assignments, alternative-service personnel found decrepit and substandard conditions, which many determined to reform. Toward this end, they prepared and distributed various forms of literature whose purpose was to identify the deficiencies of state institutions. After the war ended, these activities were expanded via the National Mental Health Foundation, which former COs founded "to help enlighten society to the true nature of mental illness and deficiency, to cooperate with others in the promotion of mental health and the prevention of mental illness, and to seek higher standards of care and treatment in mental institutions."[15]

By the 1950s, two kinds of critiques of mental hospitals had become common. The first was the popular exposé. National periodicals constituted the primary front of a journalistic campaign against state facilities for the mentally ill. In 1946 *Life* published "Bedlam USA," and "The Shame of Our Mental Hospitals" appeared in the pages of *Reader's Digest.* As Nina Ridenour explains, "These two articles, appearing in two of the magazines with widest circulation in the United States, triggered a volcano of exposés and feature articles in other magazines and the daily press which continued for several years."[16] In this connection, beginning in the late 1940s, several major newspapers—such as the *Cleveland Daily Press, Chicago Daily News, San Francisco News,* and *St. Paul Dispatch*—assigned reporters to regular coverage of local state hospitals.[17] Other forms of the popular exposé included book-length journalistic treatments—such as Albert Deutsch's *The Shame of the States* (1948) and John Bartlow Martin's *The Pane of Glass* (1956)—and memoirs by former patients, such as Mary Jane Ward's *The Snake Pit* (1946).[18] (It is interesting to note that Ken Kesey's novel *One Flew Over the Cuckoo's Nest,* which enjoyed great success with readers and movie-

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goers in the late 1970s, actually belongs to this earlier era, having first been published in the early 1960s.)[19]

The second form of critique was social-scientific, and focused characteristically on "the *consequences* of the structure, functions, professional composition and relationships, or institutional environment of a particular facility for individual patients."[20] Psychiatrists, anthropologists, and sociologists were involved as researchers who produced such titles as *The Mental Hospital* (1954), *Human Problems of a State Mental Hospital* (1956), *The Psychiatric Hospital as a Small Society* (1958), and *Asylums* (1961).[21]

In the end, these hospital exposés and studies did much more than simply elaborate a critique of existing institutional arrangements for the care of the mentally ill. They also helped to alter the image of mental illness by identifying yet another external cause of this disability—the hospital itself—as the following samples each illustrate:[22]

> Nobody knows how many curables have been rendered hopeless by the nightmarish trials of state hospital life.
>
> Our study, then, is of the hospital as a whole, as a highly organized functioning institution, in both its formal and informal aspects. It is based on the reasonable hypothesis that at least some aspects of the disturbances of the patients are a part of the functioning of the institution.
>
> In response to his stigmatization and to the sensed deprivation that occurs when he enters the hospital, the inmate frequently develops some alienation from civil society, sometimes expressed by an unwillingness to leave the hospital. This alienation can develop regardless of the type of disorder for which the patient was committed, constituting a side effect of hospitalization that frequently has more significance for the patient and his personal circle than do his original difficulties.

By somewhat different routes, then, popular and scholarly writers arrived at the same ironic conclusion: Mental hospitals as currently organized were making worse the very problems they were intended to remedy.

Drugs. The discovery of tranquilizing drugs and their use in the treatment of patients was a third seminal influence on the mental health system in the post-war years.[23] Two major drugs—reserpine and chlorpromazine—first gained the attention of the scientific community at about the same time, and the process by which they were adopted in mental health care was similar. Both reserpine and chlorpromazine were developed by researchers in other countries (India and France, respectively). Both drugs initially were viewed with great suspicion by American physicians and hospital administrators, who began a series of clinical tests. And both drugs eventually won wide acceptance as valuable agents for the

reduction of anxiety and other psychiatric symptoms without making the patient unconscious.

Reserpine and chlorpromazine proved especially useful to the many mental health professionals who, by the end of the 1950s, were working to define a new, more delimited role for the state hospital. By eliminating much of the need to use physical restraints, tranquilizing drugs contributed to a positive atmosphere between staff and patients that greatly aided such new rehabilitative efforts as milieu therapy, which attempted to match the approach of the clinical personnel and the program of therapeutic activities to the problems of the individual patient. Within a short time, early discharge programs became common, and the inpatient census of public mental hospitals continued its first sustained decline in American history.[24]

Like other developments of the period, tranquilizing drugs affected the climate of opinion in mental health care in a way that carried beyond their definitively proven value as medical applications. In the first place, the new drugs kindled a spirit of hope in the care of the chronically mentally ill, where before there was dejection and resignation. Second, the development of these drugs seemed to strengthen the sometimes tenuous link between psychiatry and physical medicine, to the benefit of the images of mental health professionals and the mentally ill alike. Analysts have claimed that it "promoted psychiatrists to physicians in the eyes of some of their colleagues, and the insane to the status of patients in the eyes of many members of the public."[25] Underlying both of these transformations of attitude was a change in the apparent nature of mental illness. Because of the efficacy of drug treatments, for some observers the disorder now seemed to belong less in the intrapsychic realm of psychoanalytic psychology and more in the biochemical realm of modern science. One contemporary activist reformer sympathetic to this view judged that the significance of the new drugs was unsurpassed "in the entire history of the physiological attack upon mental illness."[26]

Epidemiology. Groundbreaking work in the field of psychiatric epidemiology that suggested the importance of socioeconomic factors in the origins and treatment of mental illness was a fourth key development of the 1950s and early 1960s. To be sure, this focus clearly differed from that of the drug researchers, who were exploring the physiological basis of mental illness. Yet these two approaches in a sense converged, at least to the degree that both drew attention away from the individual personalities of mentally ill persons.

Two classic studies of this period typify the new epidemiological research methods and the results they produced. In *Social Class and Mental Illness*, August Hollingshead and Fredrick Redlich reviewed the records of a number of hospitals, clinics, and private practitioners in New England and New York that might have served New Haven residents who received psychiatric care within a specified period of time.[27] The authors found that a disproportionate number of

persons with emotional problems came from the lower social classes. While research of this kind could not prove that poverty caused mental illness—it was possible, for example, that people fell from higher income levels because of mental disability—it did more clearly establish an empirical relationship between social status and psychiatric problems. By reaching beyond those persons already in treatment, the "Midtown Manhattan Study" went even further in demonstrating the presence of this link.[28] Within a scientifically drawn sample of the general population of Manhattan, Leo Srole and his associates again found that lower socioeconomic groups exhibited higher rates of mental illness. Interestingly, however, Srole et al. reported that higher socioeconomic groups were more likely to receive treatment, a finding opposite to that in New Haven and due perhaps to the more sophisticated milieu and greater availability of services in Manhattan.

Together with the hospital studies by Goffman and others, the psychiatric epidemiology of the 1950s and early 1960s made manifest the growing importance of sociological research in a field heretofore dominated by medical men. Sociological research helped to place the analysis of mental health problems and services in a broad theoretical context, and it pointed the way to striking departures in treatment, leading away from hospitals and toward socially supportive modes of care. In these key ways, "Sociological research was at least partially responsible for the gradual emergence of an increasingly important alternative set of theoretical, therapeutic, and professional perspectives and models that have been termed social psychiatric and community mental health approaches."[29]

Community. A romance with the concept of "community" was a last significant background element influencing the direction that the revamping of the mental health system was to take. Daniel Moynihan has described how the juvenile delinquency and anti-poverty legislation of the early 1960s in America grew out of the idea of some intellectuals that social ills resulted from a breakdown of community in modern industrial society.[30] Eliciting the "maximum feasible participation" of lower-class groups in the structures which governed them constituted one strategy for combating this sense of powerlessness and alienation that was believed to cause various forms of social deviancy. A related notion infiltrated thinking on mental health care in this period and lent added support to the push for new community services. According to this line of thought, an individual's emotional well-being depended on his being integrated into the family and other social structures, which could provide a sense of identity and emotional balance while countering the debilitating effects of isolation.[31] Psychiatrist Jack Zusman has identified the following two beliefs as prominent elements in the philosophy of community psychiatry: "Close, long-term human relationships, particularly those within small groups, are valuable and to be fostered," and "The strength which comes from humans banding together in social groups is to be prized and utilized."[32]

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Ultimately, mental health activists found in the concept of community another effective vehicle for attacking the state hospital system. Zusman identifies the beliefs that ''Mental hospitalization is bad'' and that ''Human beings, when operating in a bureaucracy, are fallible and not to be trusted'' as two additional components of the philosophy of community psychiatry.[33] In this hostility toward the existing services and their bureaucratic structures, community mental health partisans demonstrated much in common with certain anti-poverty warriors of the early 1960s.[34]

As psychologist Charles Hersch has observed, ''No field, such as mental health, exists independently of the social framework of which it is a part. . . . The condition and spirit of the times—its social, political, and economic characteristics—will strongly influence the problems that concern us, the principles and theories that we will use to guide us, and the helping forms that we will develop.''[35] In the years during and after World War II, the mental health system began a transformation that was stimulated by a number of social, intellectual, and scientific influences. Many analysts have recorded the presence of such influences, while failing to appreciate the nature of their summary effect.[36] For this diverse collection of background forces converged to impart new social meaning to the plight of the mentally ill, by advancing a changed image of mental illness as related to social, institutional, and biochemical factors. As mental illness lost much of its status as a psychological problem growing out of individual sources of maladjustment and deficiency, the mentally ill also increasingly came to be seen as a group that was ''deserving''—a concept of longstanding importance in social welfare policymaking. This shift in perceptions led naturally to the consideration of less isolating and socially stigmatizing treatments. As we will see, concurrent developments within the mental health professions and in the state of public opinion served to reinforce these new directions in mental health care.

Professional dynamics

Conflict among professional groups both resulted from and furthered a changing understanding of mental illness during the post-war years. Traditional psychiatry came under harsh criticism in this period from those, both within and without the mental health system, who promoted new diagnoses of the problem of mental illness and new prescriptions for its treatment. There is some truth to the proposition that mental health professionals as a group helped to spearhead a self-consciously benevolent reform, and there is also some truth to the contention that they acted as a vested interest intent on acquiring federal funds and extending their sphere of influence into community life—the seemingly contradictory views of progressive and radical theorists, respectively. But more central to an analysis of the origins of a community mental health policy is the inter- and intra-

professional conflict that took place within the group of mental health professionals: it played a key part in the dynamic social process that shaped new images of the mentally ill and brought the situation of these troubled persons once again into focus as a public concern.

Sigmund Freud's ideas were first transported to America in the early 1900s. By mid-century they had largely captured the field of psychiatry and were familiar throughout the culture. Most American practitioners fused Freudian psychology with clinical medicine to produce the following model of mental illness: the individual mentally ill person was a deviant whose abnormality required treatment; emotional breakdown was akin to a disease having symptoms and other properties of organic illness; treatment for this disease should take place on a basis of one-to-one contact between the psychiatrist and his patient; and psychoanalysis should be considered a specialty on a par with other branches of medicine.[37]

For several reasons, this medical model lost much of its appeal within the public mental health system in the 1950s and '60s.[38] The Second World War had revealed the high prevalence of mental health problems in American society. By its very nature, however, psychoanalytic treatment was of little value in treating large numbers of patients. It was simply too expensive, and therapists were in insufficient supply. Also, psychoanalytic methods were not really geared to treating psychoses or persons from the bottom of the social scale. They worked best for neurotics who were relatively verbal and intelligent; these usually were upper- and middle-class patients. Just as important as these practical concerns, however, was the increasing rejection of traditional psychiatry because it seemed incompatible with the latest intellectual and theoretical directions in mental health care.

Tranquilizing drugs, in stressing the physiologic basis of mental illness, seemed to counter psychoanalytic principles of diagnosis and treatment. Some reformers seized on this opportunity to lambast the psychoanalytic fraternity. In the introduction to his book *Every Other Bed*, which was published in 1956, Mike Gorman declared war against the Freudians:[39]

> I am aware of the fact that this book will be criticized for its "excessive" emphasis upon the physiological factors underlying mental illness. I am cheerfully prepared to be read out of the Inner Temple by the High Priests of the Oedipus Complex and the rampant Id. For a number of years, I was an active communicant in that Temple, cocking an attentive ear while its psychiatric theologues concocted a witches' brew of sterile terminology to describe psychiatric phenomena they had no capability of treating. The annual incantations of the psychoanalysts, with their ritualistic excommunication of the deviationists and their Sacred Bulls quoting obscure sentences from the pen of Sigmund the Master, appear to me now as remote and fantastic as the practice of the Black Mass in the Middle Ages.

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Remarks so cutting and sarcastic betrayed an obvious frustration over psychiatry's longstanding impotence in the face of the many serious deficiencies of public mental health care. At the time when this statement was published, Gorman occupied the position of Executive Director of the National Mental Health Committee, an advocacy group that had forty-six state governors as Honorary Chairmen.

Sociological hospital studies offered another platform for the criticism of existing professional practices. Antagonism between the fields of sociology and psychiatry did not color all of this research; at least one major study of the period, for example, was coauthored by a sociologist and a psychiatrist.[40] In some other cases, however, sociologists drew clear battle lines between themselves and the established professionals of the mental health field. Goffman announced without reservation in the preface to *Asylums* that "unlike some patients, I came to the hospital with no great respect for the discipline of psychiatry nor for agencies content with its current practice."[41] In this same volume, in a closing essay subtitled "Some Notes on the Vicissitudes of the Tinkering Trades," Goffman expanded on these feelings:[42]

> The limited applicability of the medical model to mental hospitals brings together a doctor who cannot easily afford to construe his activity in other than medical terms and a patient who may well feel he must fight and hate his keepers if any sense is to be made of the hardship he is undergoing. Mental hospitals institutionalize a kind of grotesque of the service relationship.

More generally, many elements of traditional psychiatry seemed to be contradicted in the 1950s and '60s by new beliefs concerning the social aspects of mental illness.[43] While the medical model concentrated on individual intrapsychic causes, the social perspective looked at groups and communities to determine how their structures and activities affected mental health, broadly considered. At its root, the conflict between traditional psychiatrists and those persons holding to a social perspective also pertained to how mental illness should be defined. Dominant professionals had long viewed mental illness as a medical problem that would disclose itself to trained professionals through special disease symptomatology. The opposing point of view that gained strength in these years maintained that not only the etiology but also the labeling of mental illness had a social dimension, and so was to some extent relative. The concept of normality was no longer taken for granted, nor was the authority of those who claimed firmly to know the boundaries between what was normal and abnormal.

In contrast to the individual-oriented medical model, the new ideology of community mental health more closely resembled a "public health approach":[44]

> Here there is a move from a focus on the individual patient to a focus on large populations. The purpose of intervention is to reduce the incidence of disability or disease in such a population. Therefore, a special value is placed

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> on primary prevention rather than on cure, and prevention paradigms are presented along with treatment paradigms. Professional attention is placed not only on the casualties of damaging environments but on the damaging environments themselves.

Thus many forward-looking concepts in community mental health care, such as prevention through timely treatment and removal of social stress, were not really new; they were borrowings of theories and methods that had long been applied to deal with physical health problems that affected large populations.

Carried to extremes, these two notions—that mental illness is socially defined, and that removing environmental causes of mental illness is necessary for prevention—could result in intellectual formulations that were in stark contrast to the views of traditional psychiatry. One such formulation was the argument that mental illness was a "myth." Another was that mental health care should properly lead to social activism.

The most forceful proponent of the first view was himself a psychoanalyst and psychiatrist. In *The Myth of Mental Illness*, published in 1961, Thomas Szasz opened fire on many of his colleagues for likening their own professional activities to the approaches of organic medicine. "It is customary to define psychiatry as a medical specialty concerned with the study, diagnosis, and treatment of mental illness," he wrote. "This is a worthless and misleading definition. Mental illness is a myth. Psychiatrists are not concerned with mental illnesses and their treatments. In actual practice they deal with personal, social, and ethical problems in living."[45] Szasz declared it time to lift from psychiatry its "emperor's cloak."[46] In his view, psychotherapy was not equivalent to medical treatment, and objective scientific standards did not govern the diagnosis of persons with emotional problems. Szasz, of course, was exceptionally outspoken and rebellious, and few others went so far in rejecting psychiatry's claim to status as a medical subfield. Nonetheless, *The Myth of Mental Illness* and Szasz's later books went through printing after printing, and as his ideas received a wide hearing, even moderates in the field of mental health began to question existing professional shibboleths and received wisdom.

While it was far from a dominant theme of the movement, for a number of community mental health partisans the public health model seemed to point the way to social reform activity. Psychiatric epidemiology had demonstrated a definite, if still unspecified, association between social class and mental illness, and evidence was mounting on certain environmental precipitants of mental disorder, such as those related to wartime stress. By way of such findings, some mental health activists entered a frame of mind that considered the individual patient merely a symptom of a sick society. Outpatient clinics and other new community services were needed to treat such afflicted individuals, to be sure. But to some, it was at least as important now to alter the community itself. In Hersch's words, "The mental health worker legitimated his involvement in social

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reform by simply declaring that such issues as poverty, racism, and oppression were indeed matters of mental health and that he could appropriately engage them within the framework of his professional functioning.''[47] This politicization of mental health care never really amounted to much as a coherent political force or even, at the time, as a stimulant of new radical therapies based on notions of class or race consciousness. Still, it served as one more sign of what perhaps was a much broader professional ferment in the mental health field.

The discipline of psychiatry and its seemingly conservative clinical methods thus sustained a vigorous attack on several fronts in the 1950s and 1960s. While the medical model was too firmly ensconced to be entirely dislodged, a major outcome of this process of professional dynamics was the elevation in status of other caregivers, such as social workers, psychiatric nurses, and clinical psychologists, who benefited from the declining reverence for psychiatry as well as the appearance of new modes of treatment. But even more important, the ongoing professional debate advanced new images of the problem of mental illness that contributed to the development of a new national policy.

The context of public opinion

Theorists of the progressive and social-control perspectives alike generally discount public opinion as a distinct influence in the origins of a national community mental health policy. To the extent that they recognize a change in public opinion, representatives of both schools have argued that activists simply molded or manufactured the social attitudes and beliefs that were needed to support their activities and interests.[48] This point of view conflicts, however, with the comments of many other observers that public opinion played an important sustaining, and sometimes galvanizing, role in the spread of new ideas and practices in the mental health field throughout the 1940s, '50s, and '60s. According to Jack and Patricia Ewalt, for example, one of the most significant repercussions of World War II for community psychiatry was ''the recognition by nonpsychiatric professional persons and the lay public of the ubiquitous presence of psychiatric symptoms and disability.''[49] Robert Felix, a principal architect of post-war mental health policy, has written that after the end of the war ''the arousal of the American people was rapid and dramatic. Much of the stigma of mental illness, which had been prevalent since time immemorial, began to fall away. Mental and emotional disorders were spoken of much more frankly and the need for increased knowledge, more skilled manpower, and facilities of all types was increasingly accepted.''[50] Franklin Chu and Sharland Trotter cite new elements of public opinion to help explain why the state hospital population began to decline in 1956, ten years before the first federally-funded community mental health centers began to offer services: ''The late fifties and sixties witnessed changes in social attitudes toward the mentally ill—reflected in concerted efforts by local groups to get patients out of state hospitals—and the corresponding

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increase in admissions to the psychiatric services of general hospitals and other medical facilities.''[51] And Richard Rumer states that ''heightened public consciousness of mental health care'' helped to support the establishment of community centers and in turn was expanded through the programs they offered.[52]

What was the context of public opinion in America in which the community mental health movement developed? Briefly, both levels of information about mental illness and the attitudes of the general public towards mental illness changed dramatically over the post-war period, and these changes served as another supportive influence in the formulation of a national community mental health policy.

Indirect evidence of changes. The public's growing interest in mental health matters during the 1940s and '50s is indicated by the growth of regular columns in newspapers and the publication of feature articles in national newsmagazines on mental health subjects.[53] The public seemed receptive in this period to mental health themes carried to them in other media as well. In the late 1940s, for example, several special programs on this topic were carried by radio. One of the most critically-acclaimed was ''Mind in the Shadow,'' a CBS production highlighting the deficiencies of mental hospitals. Television in its early years also aired a number of mental health programs. ''Out of Darkness,'' a 90-minute documentary that first appeared in 1956 and was later rebroadcast, showed the treatment undergone by a young psychotic woman who was slowly recovering from her illness. And in the world of cinema, Twentieth Century Fox in 1946 released *The Snake Pit*, a film based on the well-known book by a former mental hospital patient. Ridenour observes, ''This was probably the first time a mental patient as leading character had been portrayed sympathetically enough for the audience to be able to identify with her. Said to have grossed eight million dollars, this film was seen by an enormous number of people and its tremendous impact at the time was apparent in many ways.''[54]

Of course, it is far from clear who or how many listened to radio and TV programs on mental health topics, or what they learned from them. And it is even conceivable that some moviegoers viewed the protagonist of *The Snake Pit* as more ''crazy'' than sympathetic. At the very least, however, it seems obvious that radio and TV broadcasters, who all depended on pleasing their audiences, were attempting to respond to what they perceived as a newly emerging popular interest in mental health topics.

The growth of voluntary mental health organizations also suggests a changing public opinion during the post-war era.[55] About 50 state and local mental hygiene societies were in existence in the 1930s. By the late 1940s, this number had grown to about 200, of widely varying sophistication and organization. In 1950, the Psychiatric Foundation (a fund-raising branch of the American Psychiatric Association) and the National Mental Health Foundation joined together with the National Committee for Mental Hygiene to form the National Association for

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Mental Health. Ten years later, the Association listed more than 800 affiliated local and state chapters, and more than one million persons were involved as members or volunteers.

But the state of public opinion in these decades need not be solely inferred from such indirect barometers. Throughout this period, social scientists carried out a number of surveys that taken together provide direct evidence of changing public knowledge and attitudes regarding mental illness. Between 1948 and 1962, polls recorded a somewhat uneven shift in the public's ability to identify cases of mental illness (as described in different forms on a questionnaire), in the value placed on professional help to treat mental health problems, and in acceptance of the mentally ill on a personal level. Further, as public opinion grew more optimistic and more informed in these years, it also seemed to become more homogeneous; that is, the views of various socio-demographic groups seemed to come closer together over time.[56]

Surveys of the 1950s. The earliest studies of the period were not as developed —in either a conceptual or a methodological sense—as later efforts would be, but they were important for determining a baseline of relatively low information on mental illness and the widespread presence of negative attitudes toward mentally ill persons. A survey in Louisville, Kentucky in 1950 showed that, while few people would punish or ridicule the mentally ill, most respondents did not appreciate the possible benefits of outpatient mental health care. They thought of psychiatrists only as a kind of final resort for persons with the most severe emotional problems, such as those who were candidates for admission to a mental hospital.[57] Also, when presented with case descriptions of a paranoid, potentially violent housewife, and of a depressed, middle-aged man, only a small proportion of respondents could recognize the seriousness of these emotional problems. In another poll conducted in Trenton, New Jersey in the late 1940s, as many as one-fifth of all respondents gave "yes" or "yes, qualified" responses to the archaic statement that insanity was a punishment from God for sin; on a separate item, about the same proportion believed that insanity was inherited.[58] Most persons in this study did maintain that the mentally ill could be helped by treatment; however, this questionnaire item differed somewhat from that used in the Louisville survey, a common problem in comparing results across some of the studies cited here. Analysis of data from each survey revealed some large differences in opinion among subcategories of respondents, such as educational and occupational groupings.

In a rural province of Canada in 1951, a pioneer experiment in mental health education attempted to use small group discussions and local media messages to teach community residents that mental illness and health are on a single continuum of behavior and emotional well-being.[59] Within a short while, sponsors of the project became aware of considerable anxiety and antagonism in the community

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due to their work. Attitudes toward the mentally ill were not improved: the average score on a standard "social distance scale," both before and after the experiment, indicated the willingness of respondents to live in the same neighborhood with someone who had been a mental hospital patient, but not (in a hypothetical situation) to accept one as a roommate.[60] Researchers also found a clear relationship between beliefs regarding the cause of mental illness and respondents' willingness to accept social responsibility for care of the mentally ill: "Those who see the causes of mental illness residing in the economic or social system also consider themselves responsible for it, while those who see the cause as biological disclaim responsibility."[61] The findings of this study probably indicated accurately contemporary attitudes in many similar American communities. On one comparable questionnaire item, for example, the proportion of residents of this Canadian town who were able to identify cases of mental illness was similar to that in a national sample of the United States.[62]

Subsequent studies throughout the 1950s produced more mixed findings. There were seeming gains in knowledge and liberalizing of some views concerning the mentally ill, but there were also lags, both regarding certain attitudes and in particular locales. Again, the use of different study methodologies and questionnaire items makes it difficult to draw more precise conclusions. On the one side, a survey of Illinois residents conducted over a six-year period in the mid- to late-1950s found somewhat greater public sophistication about mental illness than appeared in most earlier studies of the decade.[63] Another survey of the general public, this one in the state of New Jersey,[64] suggested a declining tendency to stigmatize mentally ill persons: in this study, 61 percent of respondents reported they would tell their friends if one of their family members became mentally ill; the comparable proportion in the Louisville study of 1950 stood slightly below one-half. And in a national sample taken in 1957 for a study commissioned by the Joint Commission on Mental Illness and Health (a body that the U.S. Congress had recently created), one in four respondents stated that at some time they had felt a need for professional assistance with emotional problems, and one in seven actually reported having sought help.[65]

Other findings in these and related studies, however, seemed to point to the persistence of harsh public attitudes and limited understanding of mental illness. For example, researchers in the Illinois survey concluded that "the average man" was still largely uninformed about mental illness, and that the mentally ill generally were viewed with fear, distrust, and hostility.[66] Based on review of a number of published and unpublished survey reports, the Joint Commission in its summary comments on public information concerning mental illness asserted that the public knew the "magnitude if not the nature of the mental illness problem and psychiatry's primary responsibility for care of mental patients."[67] It also referred to a "pervasive defeatism" concerning rehabilitation of the mentally ill "that stands in the way of effective treatment."[68]

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Surveys of the early 1960s. By the early 1960s, the balance of public opinion on mental illness clearly seemed to shift in favor of greater knowledge and more sanguine attitudes. The first major study to document this shift was completed in the city of Baltimore in 1960.[69] Many of the same questions used in previous surveys were included in this study, so evidence of changing views was direct. First, respondents demonstrated a much greater ability than in earlier studies to recognize mental illness when it was described to them in case stories. There were no significant differences in this ability by age, race, marital status, and urban or rural birth; some small differences existed for groups of different education and family income, but a relatively high proportion of even the least educated and lowest status groups identified all three cases described as mentally ill. Second, a high proportion of respondents expressed the belief that it would be possible to cure different forms of mental illness. The percentages holding to this belief for a paranoid, a schizophrenic, and an alcoholic were 79 percent, 72 percent, and 56 percent respectively. Finally, a relatively large proportion of respondents did not place great social distance between themselves and the mentally ill. When administered a standard battery of survey items on a social distance scale, 81 percent said that they would not hesitate to work with someone who had been mentally ill, 50 percent "could imagine themselves falling in love with someone who had been mentally ill," and 50 percent expressed a willingness to room with someone who was an ex-patient of a mental hospital.

Two other studies during the early 1960s suggested the validity of this measured change in public opinion by demonstrating that there was nothing unique about either Baltimore or the study methodology employed there to produce such positive findings. The first was a survey of attitudes of community leaders in a district of New York City.[70] Among this group, the ability to identify cases of mental illness was similar to that in the Baltimore sample. The second study, undertaken for the express purpose of testing the generalizability of the Baltimore findings, was set in Easton, Maryland, a small urban area.[71] In this survey, both the respondents' ability to recognize mental illness and their scores on a social distance scale were comparable to those in the Baltimore study. The researcher concluded:[72]

> Results of the Mayland studies appear to indicate, first, that the population sampled is rational and humane in its verbally expressed attitudes towards mental illness and is aware of the signs of some mental disorders; second, that these results can be replicated in markedly different communities within an eastern seaboard State; and third, that although the exact relationship of the Maryland studies to earlier studies cannot be stated, apparently a significant change in verbally expressed attitudes toward mental illness has occurred in the last 10 years.

This corpus of survey research, carried out over a period of roughly a decade-and-a-half, does not lend itself to precise conclusions. Different sampling methods,

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Table 1. Percentage Recognizing Mental Illness as Described in a Case Story

Case Description	National Sample (1950)	Canadian Town (1951)	Baltimore MD (1960)	New York City (1962)	Easton MD (1962)
Alcoholic	29	25	62	63	63
Schizophrenic	34	36	78	72	77
Paranoid	75	69	91	100	89

Source: Adapted from Jon K. Meyer, ''Attitudes Toward Mental Illness in a Maryland Community,'' *Public Health Reports* 79 (September 1964): 771. The data on New York City are taken from Bruce P. Dohrenwend, Viola W. Bernard, and Lawrence C. Kolb, ''The Orientations of Leaders in an Urban Area Toward Problems of Mental Illness,'' *American Journal of Psychiatry* 118 (February 1962): 685.

numbers of interviews, questionnaire items, and geographic locations distinguish the various studies from each other. And a nearly complete dearth of public opinion data from the pre-1950 era makes it difficult to compare later with earlier attitudes and beliefs. Still, many survey specialists agreed that, by the early 1960s, public opinion regarding mental illness seemed to evidence a markedly different character from that of the late 1940s and early 1950s. At least one hint of this transformation appears graphically in Tables 1 and 2, which display the

Table 2. Percentage Expressing Tolerant Attitudes Toward the Mentally Ill

Social Distance Scale Item	Canadian Town (1951)	Baltimore (1960)	Easton, MD (1962)
I wouldn't hesitate to work with someone who had been mentally ill.	No Comparable Item	81	75
If I could do the job and the pay were right, I wouldn't mind working in a mental hospital	No Comparable Item	68	57
I would be willing to room with a former mental hospital patient.	44	51	55
We should strongly discourage our children from marrying anyone who has been mentally ill.	27	46	45
I can imagine myself falling in love with a person who had been been mentally ill.	32	51	44

Source: Adapted from Meyer, p. 771. The data for the Canadian town are taken from Elaine Cumming and John Cumming, *Closed Ranks: An Experiment in Mental Health Education* (Cambridge: Harvard University Press, 1957), p. 55, and represent attitudes as measured before the educational effort by these authors. The differences in attitudes following the educational effort were minimal.

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findings on selected common questionnaire items used in various surveys throughout this period. A publication of the U.S. Department of Health, Education, and Welfare issued in 1963 offered the following concise summary of survey studies of the past fifteen years:[73]

> The overall impression one unmistakably gets from a review of these surveys is that there has been forward motion during the past decade in terms of better public understanding of mental illness and greater tolerance or acceptance of the mentally ill. It appears to be reasonably clear that the American public does not universally reject the mentally ill, nor is it thoroughly defeatist about the prospects of treating mental illness.

Political scientist Henry Foley, author of the only book-length analysis of community mental health legislation, credits the changes in opinion summarized here to the efforts of an elite group of policymakers and activists in the post-war years to persuade the American public to share their point of view on the nature of mental illness and its proper treatment. ''Throughout the late fifties and early sixties, the mental health leadership had acted as an oligopoly,'' he writes. ''Government officials and interest group members had defined the mental health problem: the warehousing of the mentally ill. A public altered by the mental health leaders demanded resolution of the problem.''[74] Such an ambitious campaign may have aided the spread of information and new attitudes on mental illness, but it seems greatly exaggerated to say that an ''oligopolistic elite'' on its own produced the favorable context of opinion that supported development and passage of the CMHC Act of 1963. Rather, it is more realistic to conclude that a variety of prominent social influences—such as the psychiatric problems brought to light in World War II, the frequent exposés of mental hospitals, and the professional conflict within the mental health field—created in combination a public mood open to a change in mental health policy. The CMHC Act thus reflected a broad cultural shift in views of mental illness and the mentally ill that had occurred from the late 1940s to the early 1960s in America.

Politics and policy

Precursors of the CMHC Act. Although the Community Mental Health Centers Act of 1963 was a logical end for the many intellectual, professional, and social forces that had combined to produce a new image of mental illness in the post-war era, this act was not the first legislative outcome of those forces. Two important pieces of legislation in the 1940s and 1950s preceded the CMHC Act, and helped to prepare the way for this dramatic refashioning of the public mental health system in America. The first was the National Mental Health Act of 1946, and the second was the Mental Health Study Act of 1955.

The governmental beginnings of the National Mental Health Act lie in Surgeon General Thomas Parran's request to Robert Felix in 1945 to prepare legislation

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that might better enable the federal government to deal with the widespread problem of mental disabilities revealed in the course of World War II.[75] Felix, who was then assigned to the Mental Hygiene Division of the Public Health Service and who was in 1949 to become the first head of the National Institute of Mental Health, eagerly accepted this opportunity to expand ideas on a national mental health plan that he had already developed in a Master of Public Health thesis at Johns Hopkins University. The measures Felix formulated, with the help of men who had served as chief psychiatrists to each branch of the military service during the war, were passed by the Congress (almost unanimously) and signed into law by President Truman on 3 July 1946.

The National Mental Health Act of 1946 created new federal grants in three major categories: research into the etiology, diagnosis, and care of neuropsychiatric problems; professional training; and development of community clinics as pilot and demonstration efforts. A National Institute of Mental Health (NIMH), to be established within the Public Health Service, was given authority to supervise this system of grants, and a National Advisory Mental Health Council was created both to review the awarding of grants and to counsel the Surgeon General on mental health issues. In short, the National Mental Health Act greatly expanded the mental health responsibilities of the federal government, which now began to stimulate new research, increases in manpower, and the kinds of local outpatient services and facilities that were a harbinger of the comprehensive community mental health centers of the 1960s.

One does not have to accept the argument that federal agency officials were the ultimate source of America's community mental health policy to recognize the important role of these activists in helping to translate changed social perceptions regarding the nature of mental illness and its proper treatment into an issue on the governmental agenda. So it was that, as Foley and others have pointed out, NIMH under Felix's leadership became a major advocate of the move toward community care in the mental health system. To some extent, NIMH's influence derived from the dollars it disbursed and the kinds of programs it chose to support, such as research into psychopharmacology and grants to states to demonstrate the effectiveness of local community services. But perhaps just as significant was the web of political alliances that Felix and his aides spun between NIMH and key congressional leaders like Senator Lister Hill (D.-Ala.), Chairman of the Labor and Public Welfare Committee, and Representative John Fogarty (D.-R.I.), Chairman of the House Appropriations Subcommittee, who together helped set NIMH's budget. A review of this budget over a small span of years attests to the rapidly growing power of both Felix and the agency.[76] Total expenditures of NIMH rose from $4,500,000 in 1948 to $106,220,000 in 1962, the eve of the Community Mental Health Centers Act. Over this same period, the agency's grant monies soared comparably, from $3,231,000 to $91,650,000.

The immediate background of the Mental Health Study Act of 1955 was the activity of professional groups, such as the American Psychiatric Association and

the American Medical Association, that had begun agitating for a study of mental health research and training in America comparable to what Abraham Flexner had completed in 1910 in the area of medical education.[77] Along with some others (including Lister Hill), John F. Kennedy sponsored the bill when it was introduced in the Senate. Testimony before Senate and House committee hearings revealed strong support for the Mental Health Study Act from some predictable quarters, including NIMH, the National Committee Against Mental Illness headed by Mike Gorman, the American Medical Association, and the American Psychiatric Association. Feeling the pinch between rising costs for custodial mental health care and falling federal support—most service grants from NIMH had taken the form of short-term "seed money"—many states also voiced their support for the bill. On 28 July 1955, Congress passed the act unanimously.

The Mental Health Study Act called for a truly comprehensive review of the mental health system in America, a "program of research into and study of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill, such programs to be on a scale commensurate with the problem."[78] Congress gave responsibility for carrying out this comprehensive examination to a "Joint Commission on Mental Illness and Health," and it gave NIMH the authority to establish this body and choose its director. The Joint Commission was incorporated in Washington, D.C. shortly after passage of the Mental Health Study Act. Not surprisingly, it included some of the leading professional advocates of a Flexner-type report, such as its director, Dr. Jack Ewalt, treasurer of the American Psychiatric Association.

In addition to commissioning several scholarly monographs on different aspects of mental illness and mental health care, the Joint Commission issued a summary volume in 1960 entitled *Action for Mental Health*. Recommendations in this volume fell under three headings.[79] Under "Pursuit of New Knowledge," the Commission called for an expanded NIMH research program concentrating on basic rather than applied research. Under "Better Use of Present Knowledge and Experience," the Commission recommended increasing the supply of mental health manpower; it set the goal of establishing one mental health clinic to provide outpatient care for each 50,000 population group; and it advised a new role for state hospitals as intensive treatment sites that would be much smaller in size. Finally, under "Costs," the Commission asserted that spending for public mental health services in America should be greatly expanded—doubled in the next five years, tripled in ten years. To summarize, the Joint Commission drew up the blueprint for a substantially revised public mental health system in America, one that would begin to substitute the principle of community care for custodialism and that would depend, at least in the beginning, on a large infusion of federal monies.

Development of the CMHC Act. The Democratic Party's platform in 1960 affirmed federal support for community mental health, and the president-elect had a longstanding interest in programs for the mentally disabled. Shortly after

becoming president, therefore, John F. Kennedy appointed a special working group to review the Joint Commission's report, and another to study the problem of mental retardation, both with a view to formulating legislative proposals.[80] The revisionist public health perspective in mental health care was staunchly represented on the President's Interagency Task Force on Mental Health by Robert Felix of NIMH and his deputy Stanley Yolles.[81] (At this time the public health viewpoint clearly dominated NIMH, which had among its employees more M.P.H. degree-holders than any other branch of the Public Health Service.) The final legislative package, which Kennedy outlined in a special message before Congress on 5 February 1963, was a compromise of the public health and medical model approaches, in that it argued for expansion of both individual-oriented and community-wide services to combat mental illness.[82]

On a general level, the president's special message articulated many of the same assumptions, values, and conclusions regarding the problem of mental illness that had appeared in the Joint Commission's report—the ideas that had been gaining ground within the mental health community for some fifteen years. First, Kennedy emphasized the large numbers of mentally ill persons (about 600,000 in public and private institutions), and the great costs incurred in caring for them (about $1.8 billion yearly in direct public outlays). Second, the president harshly criticized state institutions for their ''cold mercy of custodial isolation.'' ''The States have depended on custodial hospitals and homes,'' he pointed out. ''Many such hospitals and homes have been shamefully understaffed, overcrowded, unpleasant institutions from which death too often provided the only firm hope of release.''[83] Third, Kennedy argued that knowledge of new therapeutic techniques, and especially the advent of psychotropic drugs, enabled new directions in mental health centering on community care and social reintegration. Finally, he stressed the importance of prevention as well as treatment in a national mental health program.

In terms of policy prescriptions, the president proposed both that Congress strengthen existing resources, and also that it fund several new services. More specifically, he asked first for grants to augment the training of professional personnel, to expand existing research, and to upgrade the quality of institutional care until new programs and facilities became operational. For new programs and facilities, Kennedy proposed federal matching grants to the states for construction of Comprehensive Community Mental Health Centers. The president also recommended the provision of planning grants and short-term project grants for initial staffing of these centers. Although Kennedy recognized that his initiatives amounted to a bold innovation in policy with respect to the envisioned federal role in funding mental health care, he pointed out that the elements of his ''comprehensive community mental health system''—emergency psychiatric units, outpatient and inpatient services, foster home care, and others—already were present in many locales. Kennedy set a goal of reducing by 50 percent in the next decade or two the number of patients under custodial care in state mental hospitals.

The president's mental health program was first introduced in the Senate as S.

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755 in early February and was referred to the Committee on Labor and Public Welfare, which was chaired by Senator Lister Hill.[84] At the same time, H. R. 3688 was introduced in the House and referred to the Committee on Interstate and Foreign Commerce, which Congressman Orren Harris (D.-Ark.) chaired. During the first round of subcommittee hearings on these bills, in March 1963, numerous witnesses from the administration, national professional and voluntary associations, and state governments came forward to testify. Transcripts of these hearings reveal what were by this time familiar contemporary themes about the nature of the problem of mental illness and corresponding deficiencies in public mental health care.[85]

Many witnesses, for example, drew attention to the large numbers of people afflicted by mental illness. Secretary of Health, Education and Welfare Anthony Celebrezze, in opening comments at the Senate subcommittee hearings, reported the estimate of institutionalized mentally ill that the president had cited in his special message, and then said that "these institutional figures cover only a fraction of the total problem."[86] Later, when questioned before the House subcommittee, Celebrezze estimated the mentally ill in America to number about 17 million.[87] In a comment that conflicts with radical theories linking the origins of community mental health to cost-cutting aims, Dr. Jack Ewalt, president-elect of the American Psychiatric Association and former staff director of the Joint Commission, discounted the likelihood that implementing a national community mental health program would produce budgetary savings "because of the huge untreated mass of humanity that now exists."[88] (It was the Joint Commission's report, after all, that had called for a tripling of public spending for mental health care.) And a joint statement of the American Hospital Association and American Psychiatric Association called mental illness America's "No. 1 health problem" that perhaps afflicted as much as 10 percent of the population in urban areas.[89] These estimates of millions of mentally ill Americans clearly worked to dissolve the myth that the mentally ill composed only a small, anomalous group that the general society appropriately stigmatized as bizarre deviants. "There has been a conspiracy of silence regarding both these afflictions—mental illness and mental retardation," stated Dr. Francis Braceland, past president of the American Psychiatric Association. "These sick people are not a race apart but they are us under certain circumstances."[90]

A second common theme in both Senate and House hearings was the decrepit and harmful conditions in state hospitals. For example, Secretary Celebrezze complained that existing public outlays for mental health care chiefly financed "pathetically minimal care in grossly inadequate facilities." He said that for years state mental hospitals were "primarily institutions for quarantining the mentally ill, not for treating them."[91] In a prepared statement submitted to the Senate subcommittee, Mike Gorman, Executive Director of the National Committee Against Mental Illness, described his eighteen-year fight against state

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mental hospitals. During questioning, he despaired of any reversal of the great harm done to many long-term mental patients: "I do not think that we are in the coming years going to be able to rectify and do much for many of the untreated who have had years of lack of treatment. . . . This has been a long process of neglect."[92] But no witness, in or out of government, voiced a stronger critique of the present sad state of mental hospital care than Robert Felix, Director of the NIMH, who exclaimed fervently: "I wish to God I could live and be active for 25 more years, because I believe if I could, I would see the day when the State mental hospitals as we know them today would no longer exist. . . ."[93]

Another significant theme surfacing repeatedly in the hearings was a comparison between mental and physical illness. In an important way this comparison revealed how the content of new views of mental illness helped to determine the choice of community-based forms of care. Boisfeuillet Jones, Special Assistant for Health and Medical Affairs, used this analogy to summarize the administration's recommendations: "What is contemplated in the mental health program, Mr. Chairman, is an effort to transfer the care of the mentally ill from custodial institutions operated almost exclusively by the States, to community facilities and services whereby those who have mental and emotional problems, can be served in their communities in a way comparable to the services provided for those who are physically ill."[94] Charles H. Frazier, representing the National Association for Mental Health, expressed the same theme in an impassioned plea: "We are not concerned alone with ways in which to relieve overcrowding and insanitary conditions, and of eliminating abandonment and neglect, of giving humane care to people in mental institutions; we are concerned with providing medical care for sick people under the very same conditions and with the very same medical consideration as obtains in the treatment of other sick people."[95] With respect to changed images of the mentally ill, such a comparison between mental illness and physical illness had obvious relevance for that important quality of deservingness, as the following comment from Special Assistant Jones regarding the new drugs attests: "The tranquilizing drugs have made quite an impact on the management of mental illness, and I think people are increasingly coming to the viewpoint that mental illness is an illness, and not a result of a scourge or condemnation for which the individual is responsible."[96]

A last common theme also shifted attention away from individual mentally ill persons in stressing the role of social influences as both the source and remedy of mental illness. Here again we see how new views ultimately helped to shape policy design. Charles Frazier, for example, encapsulated a decade of social-psychological theorizing when he explained that "separation and isolation of the patient from his relatives and friends, from his place of worship, from his normal human contacts in the community actually serve to intensify his illness and to make chronic patients out of patients who might be treated and discharged in a matter of days in a community setting."[97] Mike Gorman seconded this notion:

"So in essence what the community health center concept does, it makes the patient accessible to the general practitioner, to the family—accessible, if I may say so, to the total compassionate structure of the community, and the patient is not totally isolated."[98]

Comments such as these effectively communicated the fondness with which many intellectuals and social activists of the day viewed the somewhat vague concept of community. It seemed to represent to them an almost idyllic organicism that could embrace, and so heal, individual ills. But in one of the comparatively few hostile communications received by either congressional subcommittee, Gene Birkeland, an "Independent Research Analyst," expressed fear over this admittedly powerful concept of community. He likened the concern within the community mental health movement with social factors in the causation and rehabilitation of psychiatric disorders to Soviet psychiatry and social control. To this observer at least, the president had proposed an ominously anti-individualistic program opening "a channel for the control of human thought which will eventually cause a reversion to the Dark Ages from which it is unlikely that we will emerge."[99]

But Mr. Birkeland's forebodings, together with the complaints of a few other groups who wished for such things as greater emphasis on helping patients already in state hospitals or that psychotherapists be better trained, represented the minority sentiment, and the House and Senate subcommittee hearings were distinguished by harmonious agreement on the need for bold initiatives in community mental health care.[100] A fly did drop into the ointment in early summer, however, when the American Medical Association (AMA) came out strongly against provisions in the CMHC Act to fund the staffing for the new centers—a reaction that reflected the "socialized medicine" fears associated with the AMA's opposition to national health insurance.[101] The objections of the AMA resulted in the referring of the CMHC bill back to House subcommittee in July for supplemental hearings; but by early fall, the House and Senate had agreed on and passed a version of the act that excluded the staffing provisions, compromising on $150 million as the total funding for the new mental health centers program. The president signed the legislation on 31 October 1963.

The CMHC Act, a real departure in public policy toward the mentally ill in America, became law with comparative ease. This outcome resulted from a general consensus among Congressmen, federal agency officials, state government representatives, and activists as to the need to reform the existing mental health system. But even more determinative in the long run was the development by 1963 of widespread agreement that community care was the most suitable approach to treating mental illness in accordance with current understandings of the problem's etiology and underlying nature. Moreover, there is some evidence that administration officials and Congressmen alike perceived that a changed, "more enlightened" public opinion regarding mental illness not only would

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support a bold new policy if passed, but also, according to some participants at least, might even demand its passage.[102]

Conclusion

In 1963, the census of state and county mental hospitals in the U.S. approximated 500,000 patients. Within fifteen years, this number was cut by about two-thirds, and an extensive network of more than 500 federally-funded community mental health centers was established across the nation.[103] The community mental health movement has not been without its problems, however. Over this same period, a host of concerns has surfaced regarding the fate of chronically mentally ill persons: many of them have simply been ''reinstitutionalized'' from state hospitals to such places as nursing homes; others now reside ''in the community,'' but socially ostracized and lacking necessary social services and psychological care.

Many of these serious problems result from the way that some state governments and private-sector interests have pursued narrow political or pecuniary aims in the implementation of community mental health programs.[104] But to search for any seeds of current difficulties in the design of America's community mental health policy, we might begin by noting how sparse was the evidence of the efficacy of new community programs when America launched its ambitious national policy in 1963. Describing the period when NIMH leaders first formulated the CMHC Act, Foley observes, ''While data existed to support the feasibility of a nationwide mental health program as Felix proposed it, there were no data to prove that (as later defined in the regulations) the comprehensive approach would be effective. Admittedly, the programmatic elements in combination were not that certain of positive results.''[105] And sociologist David Mechanic maintains that ''the operation of mental health programs has proceeded more on an ideological thrust than on any empirically supported ideas concerning the feasibility and the effectiveness of particular alternatives.''[106]

Passage of the CMHC Act thus can be seen as a case study of a policymaking process based less on proven solutions to well-defined problems than on widely held social perceptions as to the nature of a particular social issue and some appropriate responses. Historically, public treatment of the mentally ill in America has always corresponded to prevailing social views regarding the nature and etiology of this problem of mental illness, whether it has been in terms of persecution of the ''possessed'' in the early colonial period, ''moral treatment'' in special hospitals for those diagnosed to be suffering from strained and overworked emotions during the first half of the 1800s, or sterilization of those considered to be genetically deficient in the late 1800s. That this relationship between shifting social perceptions and the formulation of mental health policy should persist in modern times, when we still have so much to answer definitively about what causes and what cures mental disorder, should not be surprising.

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Thus, as we seek to foresee or perhaps to influence the shape of future public policy towards the mentally ill, we ought to consider not only the state of present policy, but also the state of the iceberg of dynamic social perceptions and attitudes that underlies it. For it is this theoretical perspective that enables us to relate the policymaking process to the broader cultural context that surrounds it, and might even provide clues as to the nature and timing of the next psychiatric revolution.

Notes

1. See, for example, William E. Leuchtenburg, *A Troubled Feast: American Society Since 1945* (Boston: Little, Brown and Co., 1973), pp. 133–35; and James T. Patterson, *America in the Twentieth Century: A History* (New York: Harcourt Brace Jovanovich, 1976), p. 420. For another statement of this point of view and some defenses against it, see Richard E. Neustadt, *Presidential Power: The Politics of Leadership from FDR to Carter* (New York: John Wiley and Sons, expanded ed., 1980), pp. 156–58.
2. Title II of PL 88-164, Community Mental Health Centers Act of 1963.
3. Robert H. Felix, "Community Mental Health: A Federal Perspective," *American Journal of Psychiatry* 120 (November 1964): 429.
4. See, for example, Jack L. Rubins, "The Community Mental Health Movement in the United States—Circa 1970," part I, *American Journal of Psychoanalysis* 31 (1971): 68–70.
5. The phrase "bold new approach" is taken from John F. Kennedy's "Special Message to the Congress on Mental Illness and Mental Retardation," delivered to the Congress on 5 February 1963. See *Public Papers of the Presidents of the United States: John F. Kennedy, 1963* (Washington, D. C.: U.S. Government Printing Office, 1964), p. 127.
6. For some background on the following distinction between "progressive" and "social control" analyses of social welfare policy, see David A. Rochefort, "Progressive and Social Control Perspectives on Social Welfare," *Social Service Review* 55 (December 1981): 568–92.
7. The clearest and most formal statement of this point of view is Henry A. Foley, *Community Mental Health Legislation: The Formative Process* (Lexington, Mass.: D.C. Heath, 1975). A similar perspective is presented in Robert H. Connery et al., *The Politics of Mental Health* (New York: Columbia University Press, 1968), esp. pp. 61–64.
8. Andrew T. Scull, *Decarceration: Community Treatment and the Deviant—A Radical View* (Englewood Cliffs, N.J.: Prentice-Hall, 1977). Another version of the radical view appears in Phil Brown, "The Transfer of Care: U.S. Mental Health Policy since World War II," *International Journal of Health Services* 9 (No. 4, 1979): 645–62. Also, the entire issue of *American Behavioral Scientist* 24 (July-August 1981) is devoted to the idea of deinstitutionalization as a new form of social control.
9. Robert H. Felix, *Mental Illness: Progress and Prospects* (New York: Columbia University Press, 1967), pp. 27–31.
10. See, for example, Jack R. Ewalt and Patricia L. Ewalt, "History of the Community Psychiatry Movement," *American Journal of Psychiatry* 126 (July 1969): 45; Jeanne L. Brand, "The National Mental Health Act of 1946: A Retrospect," *Bulletin of the History of Medicine* 39 (May-June 1965): 236–37; David Mechanic, *Mental Health and Social Policy* (Englewood Cliffs, N.J.: Prentice-Hall, 1969), pp. 56–57.
11. Brand, "Mental Health Act of 1946," p. 237.
12. Ibid., p. 242.
13. John H. Marx, Patricia Rieker, and David L. Ellison, "The Sociology of Community Mental Health: Historical and Methodological Perspectives," in *Sociological Perspectives on Community Mental Health*, ed. Paul M. Roman and Harrison M. Trice (Philadelphia: F. A. Davis, 1974), pp. 21–22 (original italics).
14. For a description of the activities of conscientious objectors within mental hospitals, see Brand "Mental Health Act of 1946," pp. 237–38; Albert Deutsch, *The Shame of the States* (New York: Harcourt, Brace and Co., 1948), chap. 19; and Nina Ridenour, *Mental Health in the United States: A Fifty-Year History* (Cambridge: Harvard University Press, 1961), pp. 104–07.
15. Quoted in Deutsch, *Shame of the States*, p. 168.
16. Ridenour, *Mental Health in the U.S.*, p. 107.

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17. Deutsch, *Shame of the States*, p. 178.
18. Ibid.; John Bartlow Martin, *The Pane of Glass* (New York: Harper and Brothers, 1956); Mary Jane Ward, *The Snake Pit* (New York: Random House, 1946).
19. Ken Kesey, *One Flew Over the Cuckoo's Nest* (New York: Viking Press, 1962).
20. Marx, Rieker, and Ellison, "Community Mental Health," p. 29 (original italics).
21. Alfred H. Stanton and Morris S. Schwartz, *The Mental Hospital: A Study of Institutional Participation in Psychiatric Illness and Treatment* (New York: Basic Books, 1954); Ivan Belknap, *Human Problems of a State Mental Hospital* (New York: McGraw-Hill, 1956); William Caudill, *The Psychiatric Hospital As A Small Society* (Cambridge: Harvard University Press, 1958); and Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, N.Y.: Doubleday and Co., Anchor Books ed., 1961).
22. Deutch, *Shame of the States*, p. 28; Stanton and Schwartz, *The Mental Hospital*, p. 12; and Goffman, *Asylums*, pp. 355–56, respectively.
23. This account of the development of tranquilizing drugs relies heavily on Mike Gorman, *Every Other Bed* (Cleveland: World Publishing Company, 1956), chaps. 7 and 8.
24. Scull (*Decarceration*, pp. 82–83) points out that in a number of mental hospitals in the United States, discharges of schizophrenic patients began a sharp and consistent rise in the late 1940s, a few years before the use of drugs was widespread. For his own part, Scull relates this phenomenon to his larger argument about a shifting style of social control in capitalist societies during the second half of the twentieth century. Other analysts have pointed to such things as new administrative practices within hospitals and public demands as causes of the drop in hospital populations throughout the 1950s and '60s.
25. N. Roberts, *Mental Health and Mental Illness* (London: Routledge and Kegan Paul, 1967), p. 25, quoted in *The Mentally Ill in Community-Based Sheltered Care: A Study of Community Care and Social Integration*, Stephen P. Segal and Uri Aviram (New York: John Wiley and Sons, 1978), p. 27.
26. Gorman, *Every Other Bed*, p. 89.
27. A. B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness: A Community Study* (New York: John Wiley and Sons, 1958). A concise summary of this study appears in Peter K. Manning with Martine Zucker, *The Sociology of Mental Health and Illness* (Indianapolis: Bobbs-Merrill, 1976), chap. 6.
28. L. Srole et al., *Mental Health in the Metropolis: The Midtown Manhattan Study* (New York: McGraw-Hill, 1962); for a summary, see Manning with Zucker, *Sociology of Mental Health and Illness*, chap. 6.
29. Marx, Rieker, and Ellison, "Community Mental Health," p. 27.
30. Daniel P. Moynihan, *Maximum Feasible Misunderstanding: Community Action in the War on Poverty* (New York: Free Press, paperback ed., 1970).
31. This idea implicitly runs through much of the landmark report *Action for Mental Health* (1961) by the Joint Commission on Mental Illness and Health. See also Morris S. Schwartz and Charlotte Green Schwartz, *Social Approaches to Mental Patient Care* (New York: Columbia University Press, 1964).
32. Jack Zusman, "The Philosophic Basis for a Community and Social Psychiatry," in *An Assessment of the Community Mental Health Movement*, ed. Walter E. Barton and Charlotte J. Sanborn (Lexington, Mass.: D.C. Heath, 1975), p. 25. For an early critique of this emphasis on the concept of community, see H. Warren Dunham, "Community Psychiatry: The Newest Therapeutic Bandwagon," *Archives of General Psychiatry* 12 (March 1965): 303–13.
33. Zusman, "Philosophic Basis," p. 27.
34. See, for example, James T. Patterson, *America's Struggle Against Poverty, 1900–1980* (Cambridge: Harvard University Press, 1981), pp. 138–41.
35. Charles Hersch, "Social History, Mental Health, and Community Control," *American Psychologist* 27 (August 1972): 749. In this quote, Hersch is summarizing the views of Murray Levine and Adeline Levine, *A Social History of Helping Services* (New York: Appleton-Century-Crofts, 1970).
36. Hersch (ibid.) and Marx, Rieker, and Ellison ("Community Mental Health") identify most of the key background forces and do place them in a theoretical framework that is related to what is presented in this paper. But they neither evaluate the correspondence of social, intellectual, and professional trends with the findings of empirical public opinion research, nor do they trace the

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actual influence of these changing ideas through different stages of the policymaking process —two analytic tasks that are undertaken here.

37. Good summaries of the elements of the medical model appear in Hersch, ibid., p. 750, and in Marx, Rieker, and Ellison, ibid., p. 18.
38. See, for example, Rubins, "Community Mental Health Movement," p. 76.
39. Gorman, *Every Other Bed*, p. 12.
40. Stanton and Schwartz, *The Mental Hospital. Social Class and Mental Illness* by Hollingshead and Redlich is an example of an epidemiological study that was coauthored by a sociologist and psychiatrist respectively.
41. Goffman, *Asylums*, p. x.
42. Ibid., p. 369.
43. Marx, Rieker, and Ellison, "Community Mental Health," p. 10 and passim.
44. Hersch, "Social History," p. 750.
45. Thomas Szasz, *The Myth of Mental Illness* (New York: Harper and Row, 1961), p. 296.
46. Ibid., p. 307.
47. Hersch, "Social History," p. 751; see also Marx, Rieker, and Ellison, "Community Mental Health," pp. 34–35.
48. See, for example, Foley, *Community Mental Health Legislation*, esp. pp. 13–17; and Scull, *Decarceration*, chap. 6.
49. Ewalt and Ewalt, "History of the Movement," p. 45.
50. Felix, *Mental Health: Progress and Prospects*, pp. 50–51.
51. Franklin D. Chu and Sharland Trotter, *The Madness Establishment* (New York: Grossman Publishers, 1974), p. 31.
52. Richard Rumer, "Community Mental Health Centers: Politics and Therapy," *Journal of Health Politics, Policy and Law* 2 (Winter 1978): 531. Rumer credits the change in public views to "the continued outpouring of mental health information, starting with the World War Two revelation of the frequency of mental illness and its relative curability. Exposés of mental hospitals, too, made it difficult for people to trust in institutional efficacy" (pp. 535–36).
53. The material in this paragraph is based primarily on Ridenour, *Mental Health in the U.S.*, pp. 110–13.
54. Ibid., p. 112.
55. Ibid., pp. 124–30, 137.
56. For a clear summary of the public opinion research on attitudes and information regarding mental illness that was carried out from the late 1940s to early 1960s, see Harold P. Halpert, *Public Opinions and Attitudes about Mental Health*, Research Utilization Series, U.S. Department of Health, Education and Welfare (Washington, D.C.: U.S. Government Printing Office, 1963); for another useful summary covering studies from the 1950s up to the early 1970s, see Judith Rabkin, "Public Attitudes Toward Mental Illness: A Review of the Literature," *Schizophrenia Bulletin* 10 (Fall 1974): 9–33.
57. Julian Woodward, "Changing Ideas on Mental Illness and Its Treatment," *American Sociological Review* 16 (August 1951): 443–54.
58. Glenn V. Ramsey and Melita Seipp, "Attitudes and Opinions Concerning Mental Illness," *Psychiatric Quarterly* 22 (No. 3, 1948): 428–44.
59. Elaine Cumming and John Cumming, *Closed Ranks: An Experiment in Mental Health Education* (Cambridge: Harvard University Press, 1957).
60. Ibid., p. 108.
61. Ibid., p. 69.
62. Ibid., pp. 91–100. Shirley Star, in 1950, carried out the national sample of the U.S. to which I refer. In Table 1 of this article, some of Star's findings are presented along with the survey findings of Cumming and Cumming.
63. Jum C. Nunnally, Jr., *Popular Conceptions of Mental Health: Their Development and Change* (New York: Holt, Rinehart and Winston, 1961).
64. Audience Research, Inc., *New Jersey Mental Health Survey of the General Public* (Princeton, N.J., 1954), summarized in Halpert, pp. 9–11.
65. Gerald Gurin, Joseph Veroff, and Sheila Field, *Americans View their Mental Health* (New York: Basic Books, 1960), p. xx.
66. Nunnally, *Popular Conceptions*, pp. 28, 46.

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67. Joint Commission on Mental Illness and Health, *Action for Mental Health* (New York: Basic Books, 1961), pp. xix, xx.
68. Ibid., p. xix.
69. Paul V. Lemkau and Guido M. Crocetti, "An Urban Population's Opinion and Knowledge About Mental Illness," *American Journal of Psychiatry* 118 (February 1962): 692–700.
70. Bruce P. Dohrenwend, Viola W. Bernard, and Lawrence C. Kolb, "The Orientations of Leaders in an Urban Area Toward Problems of Mental Illness," *American Journal of Psychiatry* 118 (February 1962): 683–91.
71. Jon K. Meyer, "Attitudes Toward Mental Illness in a Maryland Community," *Public Health Reports* 79 (September 1964): 769–72.
72. Ibid., p. 772.
73. Halpert, *Public Opinions*, p. 19; Rabkin summarizes some subsequent studies of the late 1960s and early 1970s purporting to show public intolerance of the mentally ill, but she concludes that these do not invalidate the more positive, earlier survey findings: "As a general overview of the status of public attitudes toward mental illness in the early 1970s, it seems reasonable to endorse Halpert's (1969) conclusion that people are distinctly better informed and disposed toward mental patients than they have been, but a major portion of the population continues to be frightened and repelled by the notion of mental illness" ("Public Attitudes," p. 19). So progress in this area has been real but, to be appreciated, it must be judged against pre-existing attitudes, not some ideal level of acceptance. For some more recent evidence of improved community attitudes towards former mental patients, see William C. Cockerham, *Sociology of Mental Disorder* (Englewood Cliffs, N.J.: Prentice-Hall, 1981), pp. 295–299.
74. Foley, *Community Mental Health Legislation*, p. 95.
75. This account of the development and provisions of the National Mental Health Act of 1946 is based on: Foley, ibid., pp. 2–6; Brand, "Mental Health Act of 1946," pp. 238–43; and Connery et al., *Politics of Mental Health*, pp. 16–20.
76. Connery et al., ibid., p. 22.
77. This account of the development of the Mental Health Study Act of 1955 is based on Foley, *Community Mental Health Legislation*, pp. 15–20; and Connery et al., *Politics of Mental Health*, pp. 37–45.
78. Quoted in Connery et al., ibid., p. 39.
79. Joint Commission on Mental Illness and Health, pp. vii-xxiv; A good summary of the report appears in Connery et al., *Politics of Mental Health*, pp. 42–45.
80. In the end, mental retardation and mental health were dealt with in two separate titles of a single congressional act. The mental retardation portion of the bill was the Mental Retardation Facilities Construction Act of 1963, Title I, PL 88-164.
81. For a thorough description of this period when the CMHC proposal was formulated by the administration, see: Foley, *Community Mental Health Legislation*, chap. 2; and Connery et al., *Politics of Mental Health*, pp. 45–47.
82. "Special Message to the Congress on Mental Illness and Mental Retardation," 5 February 1963, reprinted in *Public Papers of the Presidents*, pp. 126–37.
83. Ibid., p. 127.
84. Good summaries of the handling of the CMHC Act in Congress appear in Foley, *Community Mental Health Legislation*, chap. 3; and Connery et al., *Politics of Mental Health*, pp. 49–56.
85. U.S. Congress, Senate, Subcommittee on Health of the Committee on Labor and Public Welfare, *Hearings on S. 755 and S. 756*, 88th Cong., 1st Sess., 1963 (Washington, D.C.: U.S. Government Printing Office, 1963); and U.S. Congress, House, Subcommittee of the Committee on Interstate and Foreign Commerce, *Hearings on H.R. 3688, 3689, and 2567*, 88th Cong., 1st Sess., 1963 (Washington, D.C.: U.S. Government Printing Office, 1963).
86. Senate Hearings, p. 16.
87. House Hearings, p. 85.
88. Senate Hearings, p. 43.
89. Ibid., p. 104.
90. Ibid., p. 57.
91. Ibid., pp. 16, 17.
92. Ibid., p. 50.
93. Ibid., p. 191.

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94. House Hearings, p. 94.
95. Ibid., p. 350.
96. Ibid., p. 98.
97. Ibid., p. 350.
98. Senate Hearings, p. 49.
99. House Hearings, p. 438.
100. Connery et al., *Politics of Mental Health*, pp. 52–53.
101. Foley, *Community Mental Health Legislation*, p. 67.
102. In House subcommittee hearings, Boisfeuillet Jones responded in the following way to a question from Representative Kenneth Roberts (D.-Ala.) as to whether patients and their families would be reluctant to use community facilities: "I think the opposite is true, Mr. Chairman. I think the American public now has a much more enlightened attitude toward mental illness than was true even 10 years ago" (House Hearings, p. 98). And Foley, based on his interviews with key participants, explains that House Committee members and staff "knew that the Joint Commission and the president's message had alerted the electorate" (*Community Mental Health Legislation*, p. 62), an observation that seems to indicate the existence of some measure of concern with the desires of the American voting public on this matter.
103. Ellen L. Bassuk and Samuel Gerson, "Deinstitutionalization and Mental Health Services," *Scientific American* 238 (February 1978): 46–53. These authors present a balanced summary of both the accomplishments and failures of deinstitutionalization and the community mental health program as these policies were implemented in the 1960s and '70s.
104. Social-control scholars have often described aspects of this process to support their argument that political-economic aims dominated America's community mental health policy from the very start. But this interpretation neglects to recognize that "formulation" and "implementation" are two distinct stages of the policymaking process that can be controlled by different forces. In short, it is often unfair and inaccurate to judge the motives of reformers by looking at the eventual outcome of the programs they sponsored. For further discussion of this general tendency among social-control theorists to judge the intentions behind social welfare programs according to the practical effects of these programs, see Rochefort, "Progressive and Social Control Perspectives," pp. 584–86.
105. Foley, *Community Mental Health Legislation*, p. 140.
106. Mechanic, *Mental Health and Social Policy*, p. 96.

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